Coverage Determination Challenge Letter

Date: [Insert Date]

[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email]

[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Re: Coverage Determination Challenge for [Patient's Name], [Policy Number]

Dear [Insurance Company Representative's Name],

I am writing to formally challenge the coverage determination made on [Date of Determination] regarding [specific treatment, medication, or service] for my [son/daughter/self], [Patient's Name].

The determination stated that [briefly summarize the reason for denial]. However, I believe this decision warrants reconsideration due to the following reasons:

- [Reason 1: Provide evidence or rationale]
- [Reason 2: Provide evidence or rationale]
- [Reason 3: Provide evidence or rationale]

Included with this letter are supporting documents including [list documents: medical records, letters from healthcare providers, etc.]. I kindly request a thorough review of this case and the reconsideration of your decision.

If you require additional information or documentation, please do not hesitate to contact me at the phone number or email address listed above.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Name]